

DIVISION OF WORKERS COMPENSATION

KS DEPARTMENT OF LABOR

800 SW JACKSON ST STE 600

TOPEKA KS 66612-1227

Phone: 785-296-3441 – Fax: 785-296-0839

Web Site: www.dol.ks.gov

**Election of Employer to Cover Employees Under
Kansas Workers Compensation Act Where Employer
has Less than \$20,000 Payroll or is Agricultural Pursuit.**

NOTICE: To be processed, ALL entries on this form must be completed. All entries, except signatures, must be neatly printed in black ink.

NOTE: This Election is effective upon receipt by the Kansas Division of Workers Compensation.

To the Kansas Division of Workers Compensation, you are hereby notified that:

Employer Name: _____

Corporate Name if Applicable: _____

Address of Employment: _____

Telephone Number: (_____)_____ Type of Business: _____

hereby elects to come within the provisions of the Kansas Workers Compensation Act pursuant to K.S.A. 44-505(b).

Valid Signature of Employer or Authorized Representative

Title of Signing Individual

Date Signed